Transition Benefits (continued)

- Chemotherapy or radiation therapy;
- Pregnancy, if you were in the second or third trimester;

If you qualify because you are in your second or third trimester of pregnancy, benefits will be considered at the *PPO* level through delivery and post-partum care. (For the newborn, this benefit applies only to the nursery charges during the initial *hospital* confinement. You must select a pediatrician in the *PPO* network in order to receive the in-network level of benefits for the initial exam and subsequent baby care. If your newborn must be transferred to another *hospital* after delivery, a *PPO hospital* should be selected or services will be considered at the non-*PPO* level of benefits.)

Employees and their eligible dependents who do not call or who elect to remain with their non-*PPO* provider after the approved transition benefit period will have their covered expenses paid at the non-*PPO* level of benefits.

When you call First Health at the toll-free number 1-800-541-1623, you need to have the following information ready:

- Date your condition or treatment began;
- Anticipated due date, if you are pregnant;
- Type of care or treatment plan;
- Name and telephone number of your *physician* or *practitioner*.

Your *physician* or *practitioner* may already be a member of The **First Health**® Network. If so, you will not need to use this transition benefit as your services already qualify for the higher level of benefits. To determine if your provider belongs to the network, to locate a *physician* or *practitioner* in your area, or to find out how to nominate your current *practitioner* or *physician* for membership in the *PPO* network, call First Health at the toll-free number.

THE FIRST HEALTH® NATIONAL TRANSPLANT PROGRAM

What Is The First Health® National Transplant Program

Christopher & Banks, Inc. desires to provide you and your family with a human organ and tissue transplant benefit that helps you obtain quality care and financially protects you from significant health care expenses. The **First Health®** National Transplant Program provides transplant services through a special network of transplant facilities. It is designed to help you obtain the transplant services that are appropriate for you and eligible for reimbursement under this plan. It includes case management and some services not otherwise covered by this plan. The medical professionals who conduct the program focus their review on the appropriateness of the proposed transplant procedures. Only those procedures that are covered and certified as *medically necessary* will be eligible under the plan.

Please note that because transplantation is a highly specialized area, not all **First Health®** Network *hospitals* are part of the **First Health®** National Transplant Program. To receive the **First Health®** National Transplant Program benefits and maximums, this must be your primary plan for payment of benefits. If this plan is secondary, covered expenses will be considered at the *PPO* or non-*PPO* level of benefits and maximums based on your choice of provider and facility.

Required Review Procedures

To enroll in the **First Health®** National Transplant Program you are required to call First Health at 1-800-541-1623 as soon as the possibility of a transplant is discussed with your *physician*. When you call, it will be necessary to provide the program with all information needed to complete the review. This call will also satisfy the prior notification requirements as outlined in the Health Care Management Services section of this plan. In order to receive the highest level of benefits, you must choose one facility within the special network of transplant facilities. Transplant related services must be received at the facility you choose in order to be covered under the National Transplant Program benefit. All transplant benefits, including pre-transplant evaluation expenses (even if the transplant does not occur), will be provided by the plan as outlined on the Schedule of Transplant Benefits.

Reduced Benefits For Failure To Follow Required Review Procedures

When the required review procedures for the **First Health®** National Transplant Program are followed and you use one of the designated transplant facilities, your benefits will be unaffected, and you and the plan avoid unnecessary expenses. However, if a transplant procedure is not performed at a **First Health®** National Transplant Program facility, the plan will pay benefits at a lower percentage, and no coverage will be provided for organ donor costs or travel, lodging and meal expenses.

If you choose not to have a transplant performed at a **First Health®** National Transplant Program facility, you must still follow the Health Care Management Services prior notification and certification requirements outlined in the previous section. If you do not follow the procedures required by this plan, the plan's payment will be reduced by $5,000 for all related covered expenses, after any applicable deductible.

The penalty assessed when you do not follow the notification and certification procedures required by the plan does not apply toward your out-of-pocket maximum.

Covered Transplants

When all of the provisions of the **First Health**® National Transplant Program are satisfied, the plan will provide benefits as outlined on the Schedule of Transplant Benefits. The types of transplants may include:

- Allogenic bone marrow/peripheral stem cell transplantation.
- Autologous bone marrow/peripheral stem cell transplantation.
- Heart transplantation.
- Heart/lung transplantation.
- Lung transplantation.
- Liver transplantation.
- Kidney transplantation.
- Kidney/pancreas transplantation.
- Pancreas transplantation.
- Intestinal/small bowel transplantation.

Covered Transplant Services

- Pre-transplant evaluation.
- Acquisition/procurement of organ(s), stem cells or bone marrow.
- Transplant procedures and associated hospitalization.
- Transplant-related follow-up care provided by the designated transplant facility for the duration of the transplant contract.
- Pharmacy supplies and services provided by the **First Health**® National Transplant Program facility for immunosuppressant and other transplant-related medications while hospitalized.
- Donor expenses, if not covered under any other plan.
- Transplant-related services provided by the **First Health**® National Transplant Program facility that are associated with the transplant events listed above, including laboratory and other diagnostic services.
- *Physician* services related to the transplant events listed above.

Covered Transplant Services (continued)

- Travel and lodging expenses if the recipient plus one other person (both parents, if recipient is under age 19), and the living donor (if applicable) live greater than 50 miles one way from the designated facility. Air travel is recommended when the recipient plus one other person (both parents, if recipient is under age 19) and the living donor (if applicable) live greater than 150 miles one way from the designated facility. Eligible auto mileage will be reimbursed as determined by the IRS. Car rentals are not covered. Your case manager may be able to assist you with travel arrangements.

- The recipient may be approved for travel to the approved facility where the transplant was performed for all transplant-related services required for 12 months following discharge of the recipient from the facility.

Transplant Services Not Covered

- Services, supplies, drugs and aftercare for, or related to, artificial or non-human organ implants or transplants.
- Services that are considered *investigational/experimental* or not *medically necessary*.
- Expenses for services which are specifically excluded under the Medical Expenses Not Covered section of this plan, unless a part of a treatment plan approved through the Health Care Management Services case management program.

GENERAL INFORMATION ABOUT YOUR MEDICAL BENEFITS

All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood.

Medical Necessity

The plan provides benefits only for covered services and supplies that are *medically necessary* for the treatment of a covered *illness* or *injury*. Also, the treatment must not be *investigational/ experimental*.

Usual And Customary Charges (U&C)

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the plan for any purpose. *Usual and customary charges* do not apply to *PPO* or MultiPlan Providers.

Health Care Providers

The plan provides benefits only for covered services and supplies rendered by a *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

Custodial Care

The plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Benefit Year

The word *year*, as used in this document, refers to the *benefit year* which is the 12-month period beginning December 1 and ending November 30. All annual benefit maximums and deductibles accumulate during the *benefit year*.

Deductibles

A deductible is the amount of covered expenses you must pay during each *year* before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that *year*.

The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits. All *PPO* and non-*PPO* deductibles are combined.

Co-Payments

Co-payments ("co-pays") are the first-dollar amounts you must pay for certain covered services under the plan which are usually paid at the time the service is performed (e.g., *physician* office visits or emergency room visits). These co-pays do not apply to your annual deductible or out-of-pocket maximum.

The co-payment amounts are shown on the Schedule of Medical Benefits.

Coinsurance

Coinsurance represents the portion of covered expenses paid by the plan and by you after you have satisfied any applicable deductible. These percentages apply only to covered expenses which do not exceed *usual and customary charges.* You are responsible for all remaining covered and non-covered expenses, including any amount which exceeds the *usual and customary charge* for covered expenses.

Use of the term "coinsurance" in this plan document does not imply that First Health insures the plan. The plan is offered by Christopher & Banks, Inc. on a self-insured basis, and Christopher & Banks, Inc. is solely responsible for all plan payments. First Health acts as the *contract administrator* and is not financially responsible for any benefits under the plan.

The coinsurance percentages are shown on the Schedule of Medical Benefits.

Out-Of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a *year*, excluding the deductible, before the plan's coinsurance increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches the annual out-of-pocket maximum, the plan will pay 100% of additional covered expenses for that individual during the remainder of that *year*.

The family out-of-pocket maximum applies collectively to all covered persons in the same family. When the annual family out-of-pocket maximum is reached, the plan will pay 100% of covered expenses for any covered family member during the remainder of that *year*.

However, expenses for services which do not apply to the out-of-pocket maximum will never be paid at 100%.

The annual individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits. All *PPO* and non-*PPO* out-of-pocket maximums are combined.

Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever, the word *lifetime* appears in this plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Christopher & Banks, Inc.

The benefit maximums applicable to this plan are shown on the Schedule of Medical Benefits.

COVERED MEDICAL EXPENSES

When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Medical Benefits for the services and supplies listed in this section. This list is intended to give you a general description of expenses for services and supplies covered by the plan.

Hospital Services

- Semi-private room and board expenses.
- Private room and board expenses, limited to the cost of a semi-private room, unless a private room is *medically necessary.*
- *Intensive care unit* and coronary care unit charges.
- Miscellaneous *hospital* services and supplies required for treatment.
- Well-baby nursery, *physician* and initial exam expenses (including screening for hearing) during the initial *hospital* confinement of a newborn. Expenses for the newborn will be considered as part of the mother's expenses.
- Expenses for treatment of a sick newborn during the initial *hospital* confinement. Expenses for the newborn will be considered separately from the mother's expenses.
- *Hospital* confinement expenses for dental services if hospitalization is necessary to safeguard the health of the patient.
- *Outpatient hospital* services.

Emergency Services

- Treatment in a *hospital* emergency room or other emergency care facility for a condition that can be classified as a *medical emergency* or *accidental injury.*
- Ground or air transportation provided by a professional ambulance service to and from a *hospital* or emergency care facility which is equipped to treat a condition that can be classified as a *medical emergency.*

Specialized Treatment Facilities

- An *ambulatory surgical facility.*
- A *birthing center.*
- A *rehabilitation facility.*
- A *skilled nursing facility*, not to exceed the cost of a semi-private room. Benefits are limited as outlined on the Schedule of Medical Benefits.

Specialized Treatment Facilities (continued)

- An *urgent care facility.*
- A *hospice facility.* Benefits are limited as outlined on the Schedule of Medical Benefits.
- A *mental/nervous treatment facility.*
- A *substance abuse treatment facility.*
- A *psychiatric day treatment facility.*
- A chemical dependency/substance abuse day treatment facility.
- A *residential treatment facility.*

Surgical Services

- Surgeon's expenses for the performance of a surgical procedure.
- Assistant surgeon's expenses, not to exceed 100% of the *usual and customary charges* for the procedure.
- Two or more surgical procedures performed during the same session. When using non-*PPO* providers, the amount eligible for consideration is the sum of *usual and customary charges* for the largest amount billed for one procedure plus 50% of the sum of *usual and customary charges* billed for all other procedures performed.
- Anesthetic services, when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.
- Human organ and tissue transplants. For a list of covered transplants, refer to the **First Health**® National Transplant Program section of this plan.
- *Oral surgery*, limited to: excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth; treatment of an *accidental injury* to the jaws, cheeks, lips, tongue, roof and floor of mouth; excision of exostoses of jaws and hard palate; treatment of cleft lip and palate; external incision and drainage of cellulitus; incision of accessory sinuses, salivary glands or ducts; frenectomies; and removal of fully or partially impacted teeth.
- *Reconstructive surgery* when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, by a *surgery* (surgical procedure) or due to an *accidental injury.*
- Breast reconstruction following a total or partial mastectomy. Benefits include prostheses and reconstruction of the non-diseased breast to restore symmetry.

Surgical Services (continued)

- *Medically necessary* removal of breast or other prosthetic implants, only if they were not inserted in connection with *cosmetic surgery*.
- Surgical reproductive sterilization.
- Circumcision.
- *Outpatient surgery*.
- Orthognathic *surgery*.
- Surgical treatment of temporomandibular joint dysfunction (TMJ).
- Penile prosthetic implants, only when necessary due to organic impotence.
- Podiatry *surgery*, limited to open cutting procedures of the foot.

Mental/Nervous And Substance Abuse Services—Benefits are limited as outlined on the Schedule of Medical Benefits.

- *Inpatient* treatment of a *mental/nervous disorder* and/or substance abuse.
- *Outpatient* treatment of a *mental/nervous disorder* and/or substance abuse.
- *Partial hospitalization*.
- Treatment of or related to eating disorders.
- Treatment of or related to attention deficit disorder (ADD or ADHD).

Medical Services

- *Physician* home and office visits.
- *Inpatient physician* visits.
- *Second surgical opinions*.
- *Third surgical opinions*.
- Dental services received after an *accidental injury* to teeth. This includes replacement of teeth and any related x-rays. Injuries caused by biting or chewing are not considered *accidental injuries*.

Medical Services (continued)

- Pregnancy-related care for all covered females. Pursuant to federal law, the plan does not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *physician* or *practitioner*, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, the plan does not, under federal law, require that a *physician* or *practitioner* obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

- Termination of pregnancy by surgical or prescription drug (e.g. mifepristone, also known as RU-486) procedures.

- Selective or non-selective reduction of multiple pregnancy provided every effort is taken to ensure the health of the remaining fetus(es) when a) one (or more) fetus is abnormal, b) when the mother's health is in danger, or c) there are three or more fetuses and they are all likely to be spontaneously aborted or delivered prematurely with a high risk of either dying or being harmed.

- Radiation therapy. However, there is no coverage provided for high-dose radiation therapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition, except as specified in the **First Health®** National Transplant Program section of this plan.

- Chemotherapy. However, there is no coverage provided for high-dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue or other hematopoietic support procedures for any symptom, disease or condition, except as specified in the **First Health®** National Transplant Program section of this plan.

- Intravenous (IV)/antibiotic infusion therapy whether in a home, *physician's* office, clinic or *outpatient hospital* setting.

- *Chiropractic services*, including related x-rays. Benefits are limited as outlined on the Schedule of Medical Benefits.

- Physical therapy from a qualified *practitioner*. Benefits are limited as outlined on the Schedule of Medical Benefits.

- *Medically necessary* massage therapy, only from a qualified *practitioner* when performed in conjunction with an established treatment program (e.g. physical or occupational therapy). A licensed massage therapist is not considered a qualified *practitioner* under the plan.

- Speech therapy from a qualified *practitioner* to restore speech loss due to an *illness, injury* or surgical procedure. Benefits are limited as outlined on the Schedule of Medical Benefits.

- Occupational therapy, excluding supplies. Benefits are limited as outlined on the Schedule of Medical Benefits.

- Cardiac rehabilitation.

Medical Services (continued)

- Non-custodial services of a *nurse* which are not billed by a *home health care agency* (i.e. private-duty nursing).
- Home health care provided by a *home health care agency*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- *Home hospice*. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Treatment of diabetes, including nutritional counseling and diabetic education.
- Dialysis.
- Treatment of or related to sleep disorders.
- Non-surgical treatment of *morbid obesity*.
- Non-surgical treatment of temporomandibular joint dysfunction (TMJ).
- *Medically necessary,* non-surgical treatment of the feet, including treatment of metabolic or peripheral-vascular disease.
- Biofeedback.

Diagnostic Testing, X-Ray And Laboratory Services

- *Diagnostic charges* for x-rays.
- *Diagnostic charges* for laboratory services.
- Pre-admission testing (PAT).
- Amniocentesis, including any genetic testing or genetic counseling performed in connection with the procedure.
- Ultrasounds. Routine pregnancy-related ultrasounds are limited as outlined on the Schedule of Medical Benefits.
- Allergy testing.
- Infertility testing, only to establish the initial diagnosis of infertility.
- Magnetic Resonance Imaging (MRI).

Routine And Preventive Services—Benefits are limited as outlined on the Schedule of Medical Benefits.

- Physicals, including associated x-rays and laboratory services.
- Gynecological exams.
- PAP tests.
- Mammograms.
- Prostate cancer screenings, including PSA tests and digital rectal exams.
- Colonoscopies.
- Flexible sigmoidoscopies.
- Vaccinations, inoculations and immunizations.
- Hearing and vision examinations.
- Well-child checkups, including routine laboratory services, hearing/vision exams and vaccinations, inoculations and immunizations.

Equipment And Supplies

- *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition; or purchase of new equipment will be less expensive than repair of existing equipment.
- Artificial limbs and eyes and replacement of artificial limbs and eyes if required due to a change in the patient's physical condition; or replacement is less expensive than repair of existing equipment.
- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.
- Oxygen and rental of equipment required for its use.
- Insulin infusion pumps.
- Compression garments (e.g. Jobst garments).
- Blood and/or plasma and the equipment for its administration.

Equipment And Supplies (continued)

- Orthopedic or corrective shoes and other supportive appliances for the feet, excluding foot orthotics.
- Allergy injections, including serum.
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or if required as a result of eye *surgery* or *injury*.
- Wigs and artificial hairpieces, only after chemotherapy or radiation therapy. Benefits are limited as outlined on the Schedule of Medical Benefits.
- Sterile surgical supplies after *surgery*.
- Contraceptive injections (e.g. Depo-Provera). Self-injectable medication dispensed at a pharmacy will be considered under the prescription drug portion of this plan. See **First Health**® Rx for a description of your prescription drug benefits.
- B-12 injections.

MEDICAL EXPENSES NOT COVERED

The plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a descriptions of expenses for services and supplies not covered by the plan.

- Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.
- Services rendered by anyone other than a covered *health care provider*.
- Treatment not prescribed or recommended by a *health care provider*.
- Services, supplies or treatment not *medically necessary*.
- Services or supplies for which there is no legal obligation to pay, or expenses which would not be made, except for the availability of benefits under this plan.
- *Investigational/experimental* equipment, services or supplies.
- Complications arising from any non-covered *surgery* or treatment, except as required by law.
- Services furnished by or for the United States Government or any other government, unless payment is legally required.
- Any condition, disability or expense sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an illegal or criminal act.
- Any condition, disability or expense sustained as a result of: duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or *accidental* atomic explosion or other release of nuclear energy, whether in peacetime or wartime.
- Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under a workers' compensation act or similar legislation.
- Educational, vocational or training services and supplies, except as specified in Covered Medical Expenses.
- Expenses for preparing or copying medical reports, itemized bills or claim forms.
- Mailing and/or shipping and handling expenses.
- Sales tax.
- Expenses for broken appointments or telephone calls.
- Charges in connection with telephonic or other electronic consultations.

Medical Expenses Not Covered (continued)

- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- Travel expenses of a *physician* or a covered person, except as specified in the **First Health**® National Transplant Program section of this plan.
- *Maintenance care.*
- Sanitarium, rest or *custodial care.*
- Expenses eligible for consideration under any other plan of the *employer.*
- Treatment or services rendered outside the United States of America or its territories, except for an *accidental injury* or a *medical emergency.*
- Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone and guest meals.
- Expenses relating to or incurred in connection with autologous hematopoietic support (e.g., autologous bone marrow transplantation or stem cell rescue), including expenses for high-dose chemotherapy or radiotherapy, for any symptom, disease or condition, except as specified in the **First Health**® National Transplant Program section of this plan.
- *Cosmetic surgery.*
- Kerato-refractive eye *surgery* (*surgery* to improve nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy, LASIK and keratomileusis *surgery*).
- Reversal of any reproductive sterilization procedure.
- Surgical or non-surgical impregnation procedures, including, but not limited to, artificial insemination, in vitro fertilization and fetal and embryo implants.
- Surgical or non-surgical treatment for the correction of infertility.
- Sex change *surgery.*
- Surgical treatment of *morbid obesity.*
- Expenses related to insertion or maintenance of an artificial heart.
- Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.
- Treatment of behavioral or conduct disorders.

Medical Expenses Not Covered (continued)

- Marital counseling.
- Family counseling.
- Sex counseling.
- Genetic counseling, except as specified in Covered Medical Expenses.
- Bereavement counseling.
- Rolfing.
- Hypnosis.
- Acupuncture.
- Fitting of eyeglasses or lenses or vision therapy supplies, unless such treatment is due to a covered *illness* or *accidental injury*.
- Hearing aids or related supplies, unless loss of hearing is due to a covered *illness* or *accidental injury*.
- Adoption expenses.
- Surrogate expenses.
- Treatment, instructions, activities or drugs (including diet programs) for weight reduction or control, except for the diagnosed condition of *morbid obesity*.
- Routine foot care, e.g. treatment of corns, callouses and toenails, except as specified in Covered Medical Expenses.
- Genetic testing, except as specified in Covered Medical Expenses.
- Pain clinic programs and facility charges.
- Foot orthotics.
- Prescription drugs and medicines. Benefits may be considered under the prescription drug portion of this plan. See **First Health®** Rx for a description of your prescription drug benefits.
- Vitamins and nutritional supplements (including prenatal vitamins), whether or not a *physician's* prescription is required. See **First Health®** Rx for a description of your prescription drug benefits.
- Drugs, medicines or supplies that do not require a *physician's* prescription.

Medical Expenses Not Covered (continued)

- Contraceptive devices (e.g., IUDs, diaphragms and implants).
- Smoking cessation treatment.
- Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

GENERAL INFORMATION ABOUT YOUR FIRST HEALTH® RX BENEFITS

Your plan has selected **First Health®** Rx as its prescription drug program. *Medically necessary* and FDA-approved prescription drugs are covered under this plan, subject to any deductibles or co-payments as outlined on the Schedule of Prescription Drug Benefits, when ordered by a *physician* or *practitioner*. To receive plan benefits, prescriptions must be filled at a pharmacy that has contracted to participate in the **First Health®** Rx network ("network pharmacy"). The plan does not provide any benefits if you use a non-network pharmacy. You may find a network pharmacy in your area by calling the toll-free number listed on your identification card.

You must present your identification card when receiving drugs and services from a network pharmacy. The network pharmacy will verify eligibility. You will be required to pay any applicable deductibles or co-payments at the time the prescription is obtained. The pharmacist should notify you if a generic drug is available, however, it is in your best interest to also ask the pharmacist about generic equivalents that may be available. To obtain maximum benefits from the program, you should usually choose Tier 1 generic drugs when available.

Prescription drug information of employees and dependents is used by First Health to administer health benefits.

Occasionally, as part of regular review, First Health, or an affiliate of First Health that assists in the formulary management of the **First Health®** Rx Program, may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since most *physicians* or *practitioners* do not indicate on a prescription what the drug is being prescribed to treat, First Health may implement these changes, including prior authorization, based on First Health criteria to confirm the intent of the prescriber. For questions and information about the prescription drug program, how to obtain prior authorization, or to inquire about specific drugs or medications not listed in this plan, please call First Health's toll-free number at 1-800-541-1623.

Paper Claims Reimbursement

If you use a network pharmacy but do not present your First Health identification card at the time of service, or if the network pharmacy is unable to process the pharmacy claim electronically for any reason, payment may be required for the full charge for the drug(s) received. You may request reimbursement of any such payments by obtaining a pharmacy claim form from your *employer* and completing the necessary information. Your prescription drug plan does not coordinate benefits with any other pharmacy or medical plans. Reimbursement will be made only if the prescription drug would otherwise be covered under this plan, and reimbursement will be based upon the amount the plan would have paid, less your applicable co-payment. Claim forms should be sent to:

First Health® Rx Prescription Drug Program
P.O. Box 8400
London, KY 40742

Any reimbursement will be sent directly to you and made according to the plan's prescription drug benefit as outlined on the Schedule of Prescription Drug Benefits. If any request for reimbursement is denied or reduced other than for co-payments or deductibles, please refer to the appeal provisions of this plan in the "How To Appeal A Denial Of Benefits or Clinical Non-Certification" section.

Formulary Management Program

First Health® Rx includes a Formulary Management Program, administered by the First Health affiliate, Coventry Management Services, designed to control costs for you and the plan. The formulary includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. Tier 1 includes primarily generic drugs; Tier 2 includes preferred drugs; and Tier 3 includes non-preferred drugs. While most generic drugs fall within the Tier 1 group, some may not, based on the clinical effectiveness of these medications. Information about the program and a copy of the current formulary was included with your medical/pharmacy identification card.

You should share the formulary with your *physician* or *practitioner* when the *physician* or *practitioner* prescribes a drug, and encourage the *physician* or *practitioner* to prescribe a Tier 1 or Tier 2 drug if possible. By choosing Tier 1 or Tier 2 preferred drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary list, your plan may elect to exclude some drugs. Please review the provisions of your plan for specific drug exclusions. See Covered Drugs Under **First Health®** Rx and Exclusions Under **First Health®** Rx for further information.

Drug Utilization Review (DUR)

When you have your prescription filled, your pharmacist(s) and/or **First Health®** Rx may access information about previous prescriptions electronically and check pharmacy records for drugs that conflict or interact with the medicine being dispensed. The system may also check for refills that are too frequent, infrequent, or which may indicate potential misuse of the medication. These checks are called drug utilization review (DUR). DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or **First Health®** Rx may contact your *physician(s)* or *practitioner(s)* to discuss an alternative drug, discuss options and prescription compliance, coordinate care and treatments, with you, and/or call the 800 number for more information. In addition, they may discuss the case with your *physician(s)* or *practitioner(s)* to facilitate the best and most cost-effective use of services.

If you choose to obtain benefits under this plan, a periodic review of prescriptions may be performed by First Health to help ensure that medications are being taken properly, and to provide health education and support. Periodic review of your prescriptions is part of **First Health®** Rx. Upon review, you or your *physician(s)* or *practitioner(s)* may be contacted by First Health personnel. These individuals will discuss the current situation and may assist in coordinating care and treatment.

The same eligibility file and prospective DUR triggers are used for both the retail and mail-order pharmacy programs.

Prescription Drug Deductible

A prescription drug deductible is the amount of covered expenses you must pay each *year* before your plan will make payments. The individual deductible applies separately to each covered person. When the individual deductible is satisfied, no further deductible will be applied to that individual during the remainder of that *year*.

The annual individual deductible amount is shown on the Schedule of Prescription Drug Benefits.

Prescription Drug Co-Payments

A prescription drug co-payment is the amount of covered expenses you must pay for each prescription before your plan will make payments. The co-payment does not accumulate toward any other plan deductible or out-of-pocket maximum.

The co-payment amounts for Tier 1 generics, Tier 2 preferred and Tier 3 non-preferred prescriptions or refills are outlined on the Schedule of Prescription Drug Benefits.

This plan also includes a mail-order program. The co-payment amounts for Tier 1 generics, Tier 2 preferred and Tier 3 non-preferred prescriptions or refills ordered through the mail-order program are outlined on the Schedule of Prescription Drug Benefits.

Dispensing Limits

The amount of drug, including insulin, which is to be dispensed per retail prescription or refill will be in quantities prescribed up to a 34-day supply (90-day supply for prescription contraceptives).

The amount of drug, including insulin, which is to be dispensed per mail-order prescription or refill will be in quantities prescribed up to a 90-day supply.

Prior Authorization

Some medications require a letter of *medical necessity* from your *physician* or *practitioner* which must be received by First Health before your prescription can be dispensed. For information about receiving prior authorization, please call First Health's toll-free number at 1-800-541-1623. If, for any reason, your request for a prescription is denied, you have the right to appeal the decision. Please refer to the "How To Appeal A Denial Of Benefits Or Clinical Non-Certification" section of this plan for information on this process.

Specialty Pharmacies

First Health® Rx has contracted with Caremark Therapeutic Services to dispense specialty drugs and help manage the cost associated with these drugs for you and your plan. Specialty pharmacies dispense high-cost medications that can be safely administered at home for chronic, complex conditions such as hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis, psoriasis and pulmonary disorders. Through Caremark, you have the ability to receive specialty drugs delivered to your home. For more information about receiving specialty drugs through your pharmacy benefit, please call First Health's toll free number at 1-800-541-1623.

Mail-Order Program

First Health® Rx has contracted with Caremark to dispense mail-order drugs. Mail order is a convenient option for use when obtaining drugs you take on an ongoing basis.

To obtain your prescription by mail, complete the Patient Profile/Order Form (first prescription only), complete the required information on the order envelope, and enclose the required co-payment and prescription. Allow up to two weeks for delivery. Be sure to complete all required information with each request. Prescriptions will not be automatically refilled. You must request a refill using one of the methods outlined in this section.

If you need medication immediately but will be taking it on an ongoing basis, ask your *physician* or *practitioner* for two prescriptions. The first prescription should be for a supply that you could have filled at a network retail pharmacy based on the limits your plan has established for retail purchases. The second prescription should be for up to a 90-day supply. Send the larger prescription with your co-payment through the mail-order prescription drug program.

To Refill Your Mail-Order Prescription

When a refill is due, mail-order services does not automatically fill the prescription and mail it. You should submit your request for refill 2 weeks before your current prescription ends to allow for mailing and processing time. You may complete the order envelope and enclose the required co-payment when you mail your request or you may call 1-888-208-9634 to talk with a customer service representative about your refill.

Enhanced Mail-Order Services

The mail-order benefit offers several other convenient ways to fill your prescription or obtain information. An enhanced Internet site is also available at My **First Health®**.

This Internet site provides the following features to help you better manage your prescription drug benefit. They are:

- Refills: You can order your mail service prescription refills on-line.
- Order Status: You can log onto the system and check on the status of your current mail service prescriptions.
- Claim Form Ordering: You can place orders for additional mail service claim forms.

If you have any questions regarding eligibility, co-payment amounts or other issues for the mail-order service, please contact First Health at 1-800-541-1623.

COVERED PRESCRIPTION DRUG EXPENSES

This section is intended to provide a general description of covered drugs and supplies under the retail and mail-order pharmacy programs. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this plan. For questions about the prescription drug program such as how to obtain prior authorization and how to locate network pharmacies (including specialty pharmacies), or to inquire about specific drugs or medications not listed in this plan, please call 1-800-541-1623.

- *Legend* drugs (except where excluded).
- State restricted drugs.
- Compounded medications of which at least one ingredient is a *legend* drug.
- Prescription contraceptives, limited to oral, injectable, patch and ring.
- Insulin and diabetic supplies, including lancets, glucose strips, ketone test strips, glucagon, glucometers (glucose monitors), alcohol wipes, insulin needles and insulin syringes.
- Peak flow meters and spacers.
- Syringes, other than insulin.
- Prescription prenatal vitamins.
- Non-narcotic analgesics – migraine (e.g. Amerge, Frova, Imitrex, Maxalt, Relpax and Zomig), limited to a combined quantity of 18 per month for all forms of medication.
- Oral impotence drugs (e.g., Viagra, Cialis) for males only, limited to 9 tablets per month.
- Stadol Nasal Spray, limited to 2 bottles per month.
- Prilosec OTC™ and OTC Loratadine, only with a *physician's* prescription.
- Prozac Weekly, limited to 4 capsules per month.
- Testosterone replacement (e.g. Androderm, Androgel, Testim, Striant) for males only.

Drugs Requiring Authorization

Some medications are covered only for specific medical conditions or for specific quantity and duration. Examples of medications that may require review are noted below, however, this list is not comprehensive and is subject to change:

- Avita or Retin-A for participants age 41 and over.
- Attention Deficit Disorder (ADD or ADHD)/narcolepsy medications for participants age 22 and over (e.g. Ritalin, Concerta, Cylert, Adderall, Desoxyn, Dexadrine, Dextrostat).
- Neuromuscular blocking agents (e.g. Botox).

Drugs Requiring Authorization (continued)

- Narcotics (e.g. OxyContin, Actiq, Palladone). Prior authorization and quantity limits may apply.

- Anorexiants or weight loss medications, only for the diagnosed condition of *morbid obesity*.

- Specialty drugs, including biotech drugs, used to treat chronic complex conditions, including, but not limited to, hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis, psoriasis and pulmonary disorders. Examples of these drugs include: growth hormones (e.g. Norditropin), immunomodulators (e.g. Enbrel, Kineret, Remicade, Humira, Amevive, Raptiva), oncologic agents (e.g. Velcade, Gleevec™), replacement enzymes (e.g. Cerezyme), endothelin receptor antagonists (e.g. Tracleer), physical adjuncts (e.g. Synvisc), hematopoietic agents (e.g. Epogen, Procrit, Aranesp) and monoclonal antibodies to IGE (e.g. Xolair). All specialty drugs are limited to a 34-day supply.

PRESCRIPTION DRUG EXPENSES NOT COVERED

The plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or prescription from a *health care provider*.

- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or from any state or governmental agency.
- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, extended care facility, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the *physician* or *practitioner*, or any refill dispensed after one year from the *physician's* or *practitioner's* original order.
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g. Rogaine® or Propecia®) or for cosmetic purposes only (e.g. Renova® or Vaniqa™).
- Drugs labeled "Caution: Limited by federal law to investigational use" or other *investigational/ experimental* drugs, even though a charge is made to the individual.
- Prescription drug benefits paid under any other plan of the *employer*.
- Prescriptions dispensed in unit doses when bulk packaging is available.
- Injectable contraceptives given in a *physician's* office. Benefits may be considered under the medical portion of this plan.
- Contraceptive devices (e.g., IUDs, diaphragms and implants).
- Non-prescription contraceptive devices, including, but not limited to, condoms and spermicidal agents.
- Immunization agents.
- Allergy injections.
- Non-*legend* drugs, including, but not limited to, over-the-counter prenatal vitamins.
- Dietary supplements, vitamins (except *legend* prenatal), fluoride supplements/rinses, anabolic steroids or irrigation solutions.
- Blood and blood plasma products.

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PRESCRIPTION DRUG EXPENSES NOT COVERED (continued)

- Fertility medications.
- Smoking cessation aids, including, but not limited to, nicotine replacement drugs.
- Therapeutic devices or appliances.
- Extemporaneous or compounded dosage forms of natural estrogen or progesterone, including, but not limited to, oral capsules, suppositories and troches.

COORDINATION OF BENEFITS

General Provisions

When you and/or your dependents are covered under more than one group health plan, the primary plan will determine benefits first without regard to benefits provided under any other group health plan.

When this plan is the secondary payor, the plan will coordinate payment with the primary plan in such a way that when this plan's payment is combined with the primary plan's payment, the total does not exceed the amount this plan would have paid if it were primary.

Government Programs And Other Group Health Plans

The term group health plan, as it relates to coordination of benefits, includes the government programs *Medicare, Medicaid* and Tricare/CHAMPUS. The regulations governing these programs take precedence over the determination of benefits under this plan. For example, in determining the benefits payable under the plan, the plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a *Medicaid* plan.

The term group health plan also includes all group insurance and group subscriber contracts, such as union welfare plans, and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Individual policies or contracts are not included.

Automobile Insurance

This plan provides benefits relating to medical expenses incurred as a result of an automobile *accident* on a secondary basis only. Benefits payable under this plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by this plan will be subject to the plan's reimbursement and/or subrogation provisions.

Order Of Payment When Coordinating With Other Group Health Plans

Any group health plan which does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1. The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent. However, if the individual is covered by two group health plans and *Medicare*, and under federal law *Medicare* is:

   - secondary to the plan covering the individual as a dependent; and
   - primary to the plan covering the individual as other than a dependent (for example, a retiree);

   then the order of payment is reversed so the plan covering the individual as an employee or retiree is secondary and the other plan is primary.

2. If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:

   - the parents are married; or
   - the parents are not separated (regardless of whether they ever have been married); or
   - a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

   If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the child but that parent's spouse does, the spouse's plan is primary.

   If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

   - the plan of the custodial parent;
   - the plan of the spouse of the custodial parent;
   - the plan of the noncustodial parent; then
   - the plan of the spouse of the noncustodial parent.

Order Of Payment When Coordinating With Other Group Health Plans (continued)

3. The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under section No. 1 above.

4. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

5. The plan that has covered the individual for the longer period of time will be considered primary.

6. If none of the above rules determines the primary plan, the allowable expenses will be shared equally between the plans.

Right To Make Payments To Other Organizations

Whenever payments which should have been made by this plan have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits

All benefits payable by the plan to a *PPO* provider are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

Special Election For Employees And Spouses Age 65 And Over

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under this plan without reduction for *Medicare* benefits. You may also choose to end coverage under this plan and enroll only in *Medicare*, however, benefits which are payable under this plan may not be covered by *Medicare*. If you choose to remain covered under this plan, this plan will be the primary payor of benefits and *Medicare* will be secondary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

Restitution To The Plan

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict or otherwise, for an *illness* or *injury*. This section is not an imposition of personal liability, but reflects the equitable obligation to reimburse the plan from any recovery by you, your dependent or representative. If another party is legally responsible or agrees to provide any compensation, you or your dependent (or legal representatives, estate, heirs or trusts established on behalf of either you or your dependent), must promptly reimburse the plan for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). If the plan has not yet paid benefits relating to that *illness* or *injury*, the plan may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent or representative.

In order to secure the rights of the plan under this section, you or your dependent hereby:

(1) Grant to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you or your dependent or your representative;
(2) Assign to the plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement; and
(3) Agree that you, your dependent, or representative will hold any compensation in constructive trust for the benefit of the plan and all its participants who have contributed to the funding of the plan.